



Title: Section 10.21 - Children with Disabilities

Policy Summary

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SECTION 10: SAFEGUARDING CHILDREN IN SPECIFIC CIRCUMSTANCES

SECTION 10.21 Children with Disabilities

10.21.1 ACKNOWLEDGEMENTS

Stockport LSCB gratefully acknowledge as the source for this document Safeguarding Disabled Children: A Practice Guide for LSCBs from the Department of Children, Schools and Families, July 2009.

10.21.2 INTRODUCTION

Children with disabilities are more vulnerable to abuse and/or neglect than children without disabilities. A large scale American study of 40,000 children found that children with disabilities were on average 3.4 times more likely to be abused or neglected than children without disabilities. Analysis of one particular Local Authority found that, although children with disabilities made up only 2% of the local child population, they accounted for 10% of children made subject to child protection plans. (Morris 1999) There is also a wide spread lack of local and national data on children with disabilities who are subject to safeguarding children procedures. (Cooke and Standen) It is reported that Local Authorities are poor at recording whether an abused child had a disability, this is in relation to both Child Protection and Serious Case Reviews. (Brandon et al) According to the Children in Need census for England, children with disabilities are over-represented among children who are looked after because of abuse and neglect.

There are a number of reasons for children with disabilities being more vulnerable to abuse including:

- They are likely to be in contact with a larger number of service providers than children without disabilities and are likely to receive intimate care from a larger number of people;
- They are more likely to spend time away from their families than children without disabilities, in short-break services, residential schools and so on;
- Children with disabilities and their families may experience inadequate and poorly co-ordinated support services. This can lead to isolation which is widely recognised as a risk factor for abuse;
- Practices which are abusive can sometimes go unrecognised. This happens in two ways: firstly, sometimes a practice is applied to a disabled child which if applied to a non-disabled child would be recognised as abusive (such as locking a child in a room in order to control his behaviour or using mechanical forms of restraints such as handling belts without sufficient guidance); secondly, for some children with disabilities a failure to provide a certain level of care can result in significant damage to their development, health and well-being, yet this is not always recognised;
- There is a common failure to consult with and listen to children with disabilities about their experiences or recognise the additional support required to facilitate communication;

- Parent's views and needs are sometimes considered before those of young people. Neglect and poor parenting are in some cases not addressed with sufficient rigour where the young person presents challenging behaviour ;
- The speed of multi disciplinary decision making, quality of risk management decision making and rigour of audit processes, can also contribute to poorer outcomes for children with more complex support needs ;
- Underpinning all the many other factors which create a vulnerability to abuse are negative social attitudes towards children with disabilities – their lives and their experiences are commonly devalued;
- Failure to acknowledge and promote the human rights of children with disabilities means that abusive practices are seen as acceptable.

In spite of this greater vulnerability, there is also evidence that current safeguarding systems do not adequately protect children with disabilities from harm. There are a number of reasons for this:

- There is a commonly held belief that children with disabilities are not abused. This can lead to a denial of, or a failure to report, abuse or neglect;
- There is a lack of awareness among carers, professionals and the general public of what the indicators of abuse or neglect are for children with disabilities. These can of course be the same as for children without disabilities but there is much anecdotal evidence of indicators of abuse or neglect being misinterpreted as being related to impairment – the most common example being where a child's behaviour is put down to her impairment rather than as a possible indicator that she has been abused or neglected;
- Those working in services for children with disabilities are commonly not trained in safeguarding children while those working to safeguard children are not familiar with children with disabilities and their needs;
- A lack of familiarity with a child's impairment can get in the way of social worker using their safeguarding expertise – statements such as "He has a mental age of 5" can inhibit social workers and undermine their confidence in their own judgement concerning safeguarding and child development;
- Children with disabilities are commonly held to be not 'credible witnesses' and therefore concerns about possible abuse may not result in a referral to children's social care, or further enquiry. A belief that the police are unlikely to investigate abuse of a disabled child can act as a halt on social workers proceeding further with a complaint;
- There is often a reluctance to challenge carers, particularly when the social worker knows that removing a child from home or a current placement would be difficult because it would be hard to find an alternative placement for the child;
- A disabled child is more likely to be in contact with a number of different services and carers: there may be information recorded in a number of case files held by a number of different services and professionals.

This means that a retrospective analysis of records could be of value – often there is a pattern of incidents being recorded but not identified, at the time, as a cause for concern. More time will often be required to gather information directly from a disabled child and specialist expertise or resources may be required.

Children with disabilities are the same as children without disabilities in that they have the same human rights to be safe from abuse and neglect, and to be protected from harm. Children with disabilities are, however, different from children without disabilities in that they have needs relating to physical and/or sensory impairment, and/or cognitive impairment. They also experience greater and created vulnerability because of negative attitudes about children with disabilities, and unequal access to services and resources.

Safeguarding strategies and activity should therefore acknowledge and address both the human rights of children with disabilities to be safe and protected from harm, and the additional action that has to be taken in order for children with disabilities to access this common human right. The specific needs and circumstances of children with disabilities should be addressed at all stages of the safeguarding process.

10.21.3 CHILDREN WITH DISABILITIES

This section is for individual professionals who are involved at the various stages of the safeguarding process – from initial referrals through to s47 enquiries. It should be used in conjunction with Stockport’s LSCB procedures.

Children with disabilities have the same right to be protected from harm as children without disabilities but they also have additional needs and some different experiences. These have implications for all stages of the safeguarding process. The purpose of this section is to help professionals in contact with children with disabilities – at any stage of the safeguarding process – to avoid common pitfalls which evidence tells us may lead to a failure to safeguard the welfare of children with disabilities.

10.21.4 INITIAL CONTACT AND REFERRAL

In Stockport’s LSCB Safeguarding procedures there are a number of flowcharts which outline each stage of the process where there are concerns about a child. The following points are important for those receiving initial queries and referrals concerning a disabled child:

- When, in children’s social care, a query relates to a disabled child, do not assume that it should automatically be passed to the Children’s Disability Team as the mainstream children’s teams also deal with children with less severe disabilities;
- A referral should be made direct to the Contact Centre as with any other referral.
- As with children without disabilities it is not always obvious from the initial contact with children’s social care that there is a safeguarding matter. Professionals, the family, the child or others may emphasise another type of need and the need for protection from harm may not always be obvious. The person receiving the query should seek information about what needs and circumstances have prompted the contact;
- Where a child is already known to the Children’s Disability Team, any contact about that child and his/her sibling should be passed to that team. The Children’s Disability Team should undertake any investigation where a child has severe disabilities, and will seek advice and support from the Early Intervention Team as required. The same applies if a mainstream children’s

team is working with a disabled child and need specialist advice and support from the Children's Disability Team.

- Where two teams are involved the Team Managers will confirm lead responsibilities at point of referral to prevent delays in completing investigations and or planning. The Children with disabilities Team will in completing their investigations and assessments ensure that the needs of other children in the family are fully considered.

10.21.5 PROVIDE CLEAR INFORMATION ABOUT THE CHILD'S IMPAIRMENT/DISABILITY

When an initial contact is passed on or a referral is made to children's social care it will be important that those receiving it have clear information in order to understand the context of any concern. In addition to establishing all the usual information, the following questions should be asked when the contact or referral concerns a disabled child:

- What is the disability, special need or impairment that affects this child? Ask about their behaviours; what their continuing health needs are and safeguarding needs.
- If you do not know how to spell a word that describes an impairment or condition ask how it is spelt. This will be important if further enquiries are required about how the condition might be expected to affect the child; Use plain english and describe the terminology.
- How does the disability or impairment affect the child on a day-to-day basis?
- How does the child communicate? If someone says the child can't communicate, try asking, "How does the child indicate s/he wants something?"
- How does s/he show s/he is happy or unhappy?
- Who is best placed (home/school/respite) to observe if the child is happy or not?
- Has the disability or condition been medically assessed/diagnosed?

10.21.6 SIGNIFICANT HARM?

It is important to be aware of the factors which should be considered to be indicators of abuse or neglect experienced by children with disabilities. Stockport LSCB guidance highlights possible indicators of physical and sexual abuse, emotional abuse and neglect. In addition, there are particular indicators that need to be considered for children with disabilities. For example:

- A carer describes a disabled child as not able to communicate any preferences at all, or does not use/learn the child's preferred method of communication;
- Equipment is issued to a child but seems to be unavailable for the child's use (for example, communication board or electric wheelchair); not using issued equipment could impair the child's development and cause significant harm.
- A parent consistently refuses to take up services, or treatment which a group of professionals would consider are in the child's best interests, support

school attendance, and or vexatious with professionals resulting a failure to access services.

These types of experiences should be taken as potential indicators of abuse or neglect and should be considered in any assessment or criminal investigation (see also the list below concerning 'significant harm'). Be aware of the particular forms that 'significant harm' may take for children with disabilities. Children with disabilities may experience the same types of physical, emotional and sexual abuse and neglect suffered by children without disabilities. However, there are also certain types of harm experienced by children with disabilities that are not always recognised. It will be important to be aware of these issues when children's social care or the police are receiving a referral concerning a disabled child.

Examples:

- Failure to meet the communication needs of a hearing impaired child to the point where his or her development is impaired;
- Failure to track or record attendance via school records and liaise with education welfare service Do not assume that non school attendance is due to a disability. Evidence needs to be provided to school for absences.
- Physical interventions (including restraint) are not carried out in accordance with good practice guidelines and the protocols agreed by the Multi disciplinary team ; (See Restrictive Physical Intervention Policy and guidance);
- Inappropriate behaviour modification through, for example, the deprivation of medication or food, limiting movement, removing essential equipment;
- a parent seeking residential schooling to the exclusion of access to ordinary family life and social and emotional development;
- Misuse of medication;
- Invasive procedures which are unnecessary or carried out against the child's will, or by people without the right skills or support;
- Being denied access to medical treatment;
- Ill fitting or inappropriate equipment which may cause pain or injury;
- Being denied mobility, communication or other equipment;
- Being denied access to education, play and leisure opportunities.

Remember that evidence of good quality care does not always mean there are no safeguarding issues.

Those who perpetrate abuse (both within and outside the child's home) may also be perceived as quality caregivers with good relationships with children, families and professionals. Their ability to engage successfully with children may be a necessity in securing the trust, privacy and opportunity which enables abuse to take place. This applies as much to children with disabilities as to children without disabilities.

The dependence on a carer by a disabled child may be such that opportunities for abuse to take place are increased because of the child's needs.

10.21.7 COMMUNICATION AND DISCLOSURE

Be aware that children with disabilities often experience greater barriers to disclosing abuse than children without disabilities. However they will do it to people they trust and

where there is an interest in their well being. Communication can be affected by both the child's impairment and by the actions of an abuser. An abuser may restrict a child's access to aids for communication, including access to vocabulary. An abuser can also threaten a child or threaten to withdraw care. Threats can be more effective where a child has high personal care needs. Dependency can both increase a disabled child's vulnerability to abuse and decrease their ability to communicate what is happening.

Additional care may need to be taken when receiving a telephone call or visit from a disabled child or adult. Duty social workers can unwittingly create barriers to communication when presented with someone whose method of communication, appearance or behaviour they are not familiar or comfortable with. If you do not understand what the person is trying to say, do not guess. Do not make assumptions based on communication method or difficulties, or on appearance or behaviour. Do not put the phone down too quickly, because someone may need extra time to speak. Find out if there are steps you can take to assist the person to communicate their concerns. Take into account that some environmental and other factors have particular significance for children with disabilities risk of harm.

10.21.8 OTHER FACTORS TO CONSIDER

Circumstances such as poverty, social and physical isolation, lack of support and other environmental factors can have a particular impact on children with disabilities and their families. These issues will obviously be considered in some detail in an assessment but those receiving initial referrals should also be aware of their significance.

a) Poverty

Families with children with disabilities are at increased risk of poverty and, at the same time, impairment can create additional costs. The financial pressures on a family and carers may increase stress, and stress can be a factor or indicator of risk of abuse. The child may become the focal point of the tensions or be seen to be the cause of the stress.

b) Social isolation

For many children with disabilities their opportunities to take part in social activities, hobbies or clubs are limited and significantly less than children without disabilities. This means children with disabilities have less access to trusted adults or peers outside their circle of immediate carers. It also means less opportunity for them to have a variety of experiences and relationships. If the only relationships or contact they have are abusive they may have nothing to compare this with and, therefore, not know that it is wrong.

c) Physical factors

A child may be at increased risk of harm if the environment restricts their ability to avoid, or remove themselves from, abusive or potentially abusive situations. An understanding of a disabled child's environment will help to develop an appropriate response to a referral to children's social care. For example:

- the child's access internally to the different parts of the home/school;
- access to and facilitation of external communication systems - private use of telephones, e-mail, internet; and
- facilitation and access to external contacts and activities.

Sometimes concerns have been raised about a particular child, or about a service they are receiving, which have not resulted in any action. There is some evidence that this is more likely to happen with children with disabilities. It will be helpful therefore to establish whether concerns have been previously raised. If such concerns have not been effectively addressed in the past the child may be at increased risk of harm.

10.21.9 INITIAL ASSESSMENTS AND CORE ASSESSMENTS

As with all children in need, an initial assessment should be undertaken in line with the Framework for the Assessment of Children in Need and their Families (2000) and, if appropriate, a strategy discussion can lead to an enquiry under section 47 of the Children Act in accordance with Stockport LSCB procedures.

Take time to gather the information you require in order to understand the context of the concern, the nature of the child's needs and the risks to the child's welfare. The additional needs of children with disabilities, and the particular issues relating to safeguarding their welfare, mean that more time may be required to gather information and you are likely to have to seek information from more people than in the case of carrying out an assessment of a non-disabled child.

As part of any assessment and investigation, the areas below must be considered:

a) Carers

- What are the arrangements for caring for the child? There may well be carers additional to those usually involved with children without disabilities. For example, respite foster carers, social workers, family support workers, residential short-break carers, community/home-based support workers, sitters, home help, volunteers, advocates, play and development workers;
- Where does the child get looked after and when? For example, hospital, residential short breaks, residential school, holidays, foster carers?

b) Health

As well as a Social Care assessment a continuing health care assessment maybe necessary to support the in the most appropriate way. A disabled child may be in contact with a large number of health professionals. These professionals may be vital sources of information about both the child's needs and their experience or risk of harm:

- GP
- School nurse
- Health visitor
- Community/District nurse
- Hospital Consultant
- Paediatrician
- Physiotherapist
- Occupational therapist
- Dietician
- Speech and language therapist
- Clinical psychologist

- Psychiatrist
- Complementary health workers

c) Education and schools

Children with disabilities, whether in a mainstream or special school, are likely to be in regular contact with a number of people in a number of different roles:

- Teachers
- Special educational needs co-ordinator (SENCO) or Inclusion Coordinator, Special Education Service staff
- Teaching assistants
- Lunchtime assistants
- Transport drivers
- Transport escorts
- Volunteers
- Peripatetic teachers
- Providers of out-of-school activities – horse-riding, swimming, leisure centre.

A disabled child is more likely to receive care from a number of adults and this is a risk factor in itself.

The increased amount of exposure a disabled child has to a number of adults raises their vulnerability to being abused by someone. There is also more room for miscommunication or assumptions that 'someone else' is addressing concerns. Children may have less contact with their parents if they receive short break or looked after services, or are in a residential school.

This means s47 enquiries may be more complex and may take longer to complete. There may be more adults to be interviewed and more potential perpetrators. These difficulties need thorough consideration in the strategy discussion to ensure all risk factors are identified and contamination of evidence is avoided, and more than one strategy discussion may need to happen to plan the investigation at each stage. Recognise that you may need to seek specialist advice and information in order to make judgements about whether a child is suffering or likely to suffer significant harm, and what action should follow.

Some examples of specific forms of significant harm which may arise for children with disabilities were above. Such issues may fall outside your previous experience and you may need to ask many more questions and seek specialist advice to inform your judgment. Specialist advice may be necessary in the context of a number of judgements to be made, including:

- The impact of potentially abusive behaviour upon the physical and psychological development of the child;
- The long and short term consequences of any impairment caused by abusive behaviour or neglect;
- The emotional consequences of abuse and neglect;
- The ability of the child to engage in, or the availability of, therapeutic services.

10.21.10 HUMAN RIGHTS

All children have a number of human rights: the right to be protected from harm and have basic physical and social needs met; the right to respect private and family life; the right to know, the right to peaceful protest; the right to free expression and the right to receive equal treatment. The latter right has been reinforced by the Disability Discrimination Acts 1995 and 2005.

A failure to recognise the human rights of children with disabilities can lead to abusive situations and practices. Needs relating to impairment, and discrimination against children with disabilities, can mean that particular effort is required to identify and meet the basic human rights of children with disabilities. These areas include food and nutrition, appropriate levels of discipline or sanctions, finances, hygiene, physical comfort, social interaction, sexuality, liberty and sleep. These basic rights can be abused either through ignorance, lack of appropriate resources or support, or with intention to cause harm. Whether abuse of rights is unintentional or not, it is not acceptable for this to go unchallenged, as this does not promote children's welfare or safety. Moreover, when human rights are denied, children are vulnerable to further types of abuse.

Organisational culture and 'custom and practice' can contribute to institutional abuse or harm. Do not underestimate the power of tradition or how poor practice can become pervasive in influencing staff to behave inappropriately. Unreflective practice and risk averse approaches from staff members can significantly reduce the quality of life for young people. Such cultures can also become ideal contexts for determined abusers to manipulate both children and adults. Good quality services readily seek the views of young people, parents and other professionals in reviewing their practice.

The significance of poor practice should be assessed in the context of the impact on the particular child. For example, if insufficient time is given for a child with restricted arm and hand movement to have adequate lunch, the child could experience hunger or dehydration. A one off experience like this may not be very damaging, but consider the impact of such an experience if it is repeated over a few days or weeks.

In considering these factors, be aware that poor care practices can have more significant consequences for some children with disabilities than for children without disabilities. Poor care practices that, for a non-disabled child, may affect their emotional and physical development, may be life-threatening for a disabled child. The intimacy of the care needed by many children with disabilities also means that a lack of privacy and dignity can be abusive.

10.21.11 HEALTH

Medical and health issues have particular implications for identifying significant harm. The potential to abuse or neglect children through medical and health issues is greater than with children who are not as reliant on specific health needs being met. The main areas of concern are:

The misuse of medication:

- to restrict liberty;
- to control emotion and behaviour; and
- to impair physical and emotional capacity to resist abuse.

The neglect of health needs:

- Poor, uncoordinated or non-existent assessment of need;
- Poor equipment, adaptation and aids, which may result in harm. For example, a child who is constantly being made sore by an ill fitting back brace with no-one addressing this;
- Tampering with equipment to restrict liberty. For example, removing batteries out of an electric wheelchair might equate to a non-disabled child being locked in a room or having their legs tied;
- Neglect of basic health care needs. For example, teeth cleaning, hair washing;
- Failure to consider the socialisation and it's importance on the emotional well being of the child and access to play and leisure opportunities;
- Insufficient consideration of the developing sexual and relationship needs of the young person as they develop towards adulthood ;
- Denying or restricting access to food and nourishment. For example, if a child cannot help themselves to a drink it is abusive to withhold drink as a punishment or for malicious reason.

Experiences such as these can inhibit children's ability to reach their full potential and also can affect their ability to resist abusive behaviours towards them, making them more vulnerable to further abuse.

10.21.12 PHYSICAL INJURY

If someone tells you that a child's injury or behaviour is a normal part of their disability make sure you verify this opinion. You could do this either by asking other individuals who know the child or seeking written evidence by looking at care plans or school records. For example, if the concern regards suspicious bruising and someone says the child often gets bruising like this, look at medical and school records. The times when the child has been bruised in this way should have been noted by doctors, teachers and physiotherapists. A previous occurrence, however, should not act as verification of 'normality' and it may be necessary to seek medical or other specialist advice.

10.21.13 COMMUNICATION AND WISHES AND FEELINGS

Children with disabilities may have different communication needs. They may use other communication systems such as British sign language, symbols or hand gestures (e.g. Makaton, Rebus). The child might have very limited communication with only a sign or word or movement that indicates yes and another that indicates no. This does not mean the child cannot understand or is not able to communicate what has happened to them. It is important to note that there will always be someone in school/respite facility/or family who knows how best to communicate with the child.

If a parent or professional tells you that a child cannot communicate explore a bit further with them what he or she actually means. Ask how do they know when the child is in pain? Hungry? Hot/cold? Or doesn't like something? This will then inform you of how the child communicates.

For some children, their only way of communicating with you will be through changes in their behaviour. It is very important therefore to maximize the use of observation and reports from those in contact with the child. For example, where a child's response to personal care changes suddenly; or where they express fear or aversion to a particular carer.

It is essential that full consideration is given to how to communicate with a child when undertaking an assessment. An advocate or interpreter may be required, and it is essential that staff familiarise themselves with different communication systems and develop skills in their use or which professionals can assist with communication. Consideration should be given to utilizing existing staff who have a knowledge of the child and their form of communication and who is not involved in the allegation.

Do not think that because a child has a different ability to understand the world that they will not be affected by being harmed or neglected.

Abuse and neglect are as harmful for children with disabilities as they are for children without disabilities. Sometimes it is thought that because a child has impaired cognitive functioning (learning disabilities) they will not understand that what has happened to them is abuse or will not suffer from being neglected. For example, it may be assumed that, if a child has very limited understanding of sexual activity and relationships and sexual abuse is perpetrated in a 'loving' way, the child will never realize that they have been abused. The psychological impact of physical or emotional abuse or neglect may also be underestimated. It is sometimes concluded that, as long as the abuse stops, there will be no other impact on the child, and no reason to consider further protection or therapeutic services.

However, children with disabilities can also suffer from stress, anxiety and depression, and be severely emotionally affected by what has happened to them. Agencies working with children with disabilities need to be aware that if a child or young person has no or limited communication, this emotional impact may show itself in other ways such as self-harming, aggressive or destructive behaviour, or withdrawal. It is essential that the child or young person does not become "the problem" as a result and that children and young people are supported through a difficult time for them.

10.21.14 STRATEGY DISCUSSIONS AND ASSESSMENT/INVESTIGATIVE INTERVIEWS

A strategy discussion, convened by social care, must always take place where there are concerns that a child may be at risk of significant harm. The meeting is key to sharing information and making clear decisions about how to proceed, and it is essential that all agencies involved with that child and family participate.

With a disabled child, more than one strategy discussion may be needed, as the planning of the investigation will be complex and take time. However, this must not prevent any concern of significant harm being properly investigated. Issues for additional consideration at a strategy discussion concerning a disabled child are:

- Is it appropriate for the child to participate in a best evidence interview?
- Does the child need a supporter or advocate;
- What are the child's communication needs and who is to ensure they are met?

- Arranging for interpreters and signers to facilitate communication;
- When is the best time, venue, location to interview the child – how should it be structured (a child may be more alert in the morning, need disabled access, be able to access IT, need significant preparation before an interview). Consideration must be given to a Best Evidence Interview and reason why not pursued recorded; however, if an interview is not able to comply with the evidential requirements, a child should still be interviewed;
- Has the child personal care needs that need support during any interview;
- Will the child need medication or health support (eg if diabetic or has epilepsy);
- How is the child getting to the venue and who is transporting;
- If a parent or carer is suspected of abuse and needs to leave the family home, what support services will be needed for the child to remain at home – it must be a last resort to accommodate a child;
- What other sources of evidence are available to be considered if there is a possible criminal charge – is it appropriate for the child to have a medical, is there forensic evidence that can be gathered, has someone else observed an abusive situation, what is recorded in records.

These are issues which are complex – however, they must not prevent any concern being investigated in line with Stockport LSCB procedures, nor can any investigation not proceed on the basis that the child cannot communicate, isn't a credible witness because of his/her disability, or time and resource problems.

If the conclusion of the investigative process is that concerns are substantiated and the child is at continuing risk of significant harm, than a child protection conference must be considered. If the process has not evidenced significant harm, it must be clear what ongoing needs the child and family have, and how these should be met via the Child in Need process.

10.21.15 SPECIFIC CIRCUMSTANCES

a) Children in Residential Care and Residential Schools

Children living away from home are particularly vulnerable, as family contact may be reduced because of distance, or family support is weak because of a breakdown in the family circumstances. Children are also exposed to a high number of carers in these settings, which again increase the risk of abuse. For residential care and schools in Stockport's LSCB's area, all establishments must have the following in place:

- A clear safeguarding and child protection policy which highlights the vulnerability of children with disabilities;
- Clear guidance on the use of medication, eating and drinking, intimate care;
- Clear guidance on restrictive physical intervention (restraint), which defines what is and is not acceptable;
- Risk assessments which clearly outline how the child's needs for care, supervision and safety are to be met, and what are permissible forms of restraint and control;
- All staff have attended the LSCB training on Children with disabilities;
- A clear procedure regarding allegations against staff is in place. If an allegation is made against a member of staff working in the Stockport area

then a referral needs to be made to the Local Authority Designated Officer (LADO) at the Safeguarding Children Unit under the Allegation Management Procedure.

- If the member of staff is working in another Local Authority then a referral should be made to the appropriate Safeguarding Children Unit. (hyperlink LADO procedures)

Where a child is placed outside of Stockport, the placing social worker must confirm together with the Contracts Section that the above is in place as part of the contract agreement. If Social Care are involved in the planning and financing of a child's placement then the child will become Accommodated under S20 The Children Act 1989 and the care plan will be independently reviewed by the Safeguarding Children's Unit.

It is essential that children are regularly visited and where necessary, an advocate or independent visitor is appointed to ensure that contact is made with the child, and their views sought about their care.

b) Children in health care settings

All health care settings (hospital adult and children's wards, hospices, nursing homes) must have appropriate safeguarding and care policies in place for children with disabilities as outlined in the previous section. Again, if a child has been in hospital for 3 months or the intention on admission is that he/she will be there for 3 months or longer, social care must be notified by the Hospital Trust under s 85 of the Children Act 1989 and an assessment undertaken to ascertain how their needs are being met and how their welfare is being safeguarded.

c) Disabled young people who are accused of abuse

Studies of adolescent sexual offenders have found that between a third and a half are children and young people with learning disabilities. This group are also overrepresented amongst those being treated for harmful sexual behaviour. It is not clear why this is but one relevant factor is that many of the young perpetrators have also been abused themselves – and children and young people with learning disabilities are particularly vulnerable to abuse. Successful interventions with young abusers require specialist treatment and it is important that disabled young people are not denied access to such treatment. Multi-agency assessment and joint-working will be particularly important for this group of young people. Specialist input from learning disability services is available, even if the young person's level of impairment would not normally meet the service's eligibility criteria.

10.21.16 USEFUL TOOLS AND CONTACTS

All Join In

This is a video/DVD about communication, inclusion and emotional literacy. It was made with a diverse group of 3-7 year olds. Produced by Triangle and the NSPCC in 2004. It is available from www.triangle-services.co.uk ; Triangle, Unit E1, The Knoll Business Centre Hove BN3 7GS. Tel 01273 413141; Fax 01273 418843.

Communicating with Vulnerable Children: a guide for practitioners

This book by Dr David Jones was commissioned by the Department of Health and published by Gaskell in 2003. It includes some information about communicating with children with disabilities.

Email: custserv@turpindistributions.com

How it is

This is an image vocabulary for children about feelings, rights and safety, personal care and sexuality. It was developed - with the involvement of over 100 children - to support children to communicate about a range of important issues and was designed to fill the gaps in existing symbol vocabularies. There are 380 images available for free download www.howitis.org.uk or as a booklet with CD Rom from Triangle (see above for contact details).

How to use Easy Words and Pictures

This guide is produced by the Disability Rights Commission www.drcqb.org/library/publications.aspx

I'll Go First:

The planning and review toolkit for use with children with disabilities by Lucy Kirkbride, this Pack was designed for use with children in short term foster care, family-based short term care, in a residential children's centre or with a statement of special educational needs. Published by The Children's Society. <http://www.childrenssociety.org.uk/> The Children's Society, Edward Rudolf House, Margery Street, London, WC1X 0JL. Tel. 0845 300 1128.

Talking Mats

Talking Mats™ is an interactive resource that uses 3 sets of picture symbols: topics; options relating specifically to each topic; and a visual scale in order to allow participants to indicate their general feelings about each topic and option. For example, whether they are happy, unsure, unhappy. The AAC Research Unit has produced packages relating to Talking Mats™ and training is available. Further information from: AAC Research Unit, University of Stirling, Stirling FK9 4LA. Tel: 01786 467645 Email: aacscotland@stir.ac.uk www.aacscotland.com .

Talking Point

www.talkingpoint.org.uk - I CAN runs a website called Talking Point. This provides information about speech, language and communication difficulties in children. The site is for parents and professionals who help children with speech, language and communication difficulties and includes speech and language information, a glossary, a directory of resources, news, case studies, discussion groups, ask-the-panels write ups and frequently asked questions.

The Child's World (assessing children in need)

Training and Development Pack Produced by the NSPCC in 2000, this includes a video of children with disabilities and children without disabilities giving their experiences of assessment. NSPCC Training and Consultancy, 3 Gilmour Close, Leicester LE4 1EZ. Tel 0116 2347223.

Two Way Street: Communicating with Children with disabilities and Young People

A training video and handbook about communicating with children with disabilities and young people. The video is aimed at all professionals whose role includes communicating with children and was developed in consultation with children with disabilities and young people. The handbook (also available separately) gives further information and guidance plus details of the main communication systems in current use in the UK and annotated references to good practice publications. See above for Triangle's contact details.

In My Shoes

In My Shoes is a computer package that helps children and learning disabled adults communicate about potentially distressing experiences. Extensive testing shows it can be used in a wide range of circumstances, including with children who may have been abused. It has been used successfully in interviewing vulnerable adults. For further information contact:

Liza Bingley, Email: liza.miller@ntlworld.com or write to Child and Family Training Services, P O Box 4205, London W1A 6YD or Tel. 01904 634417.

The ABCD Pack – a Training and Resource Pack for Trainers in Child Protection and Disability

The ABCD Pack is a training and resource pack to assist trainers to design courses that help to:

- Raise awareness of child abuse and disability
- Prevent the abuse of children with disabilities
- Investigate and assess possible abuse
- Empower and support abused and children with disabilities
- Identify the implications of this work for managers.

The pack has 5 modules:

- Foundation and Awareness
- Prevention
- Investigation and Assessment
- Survival
- Management and Policy.

The material was developed with two target groups in mind:

- Everyone who works directly with, or whose agency provides a service for, children with disabilities
- Everyone involved in safeguarding work.

It is available from: NSPCC Training and Consultancy, 3 Gilmour Close, Leicester LE4 1EZ. Tel 0116 2347223

Achieving Best Evidence in Criminal Proceedings: Guidance for Vulnerable or Intimidated Witnesses, including children

This is guidance on the implementation of the special measures in relation to vulnerable witnesses in the Youth Justice and Criminal Evidence Act 1999. It addresses the needs of children with disabilities and young people (and other vulnerable groups) as witnesses within the criminal justice system. Special measures within the Act include:

Section 29: Use of an intermediary. A person may be appointed by the court to act as an intermediary between the witness and the court to make clear to the witness questions put to them and enable the court to understand their responses.

Section 30: Aids to communication. These may be used to enable the witness to give best evidence, for example by signs and symbols, communication boards or electronic equipment.

Achieving Best Evidence includes extensive guidance on providing the necessary adaptations to investigation and prosecution when children with disabilities or adults are involved as witnesses, including Appendix G Guidance on Investigative Interviews with Disabled Children.

Home Office, Lord Chancellor's Department, Crown Prosecution Service, Department of Health, National Assembly for Wales (2002) Achieving Best Evidence in criminal Proceedings: Guidance for Vulnerable or Intimidated Witnesses, including children.

Home Office. <http://www.cps.gov.uk/publications/prosecution/>